REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ONE FORM PER CHILD

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Account /Chart: _____

Street Address

_____ Phone # _____

City, State, Zip

For Record Release or Copies: By signing this authorization, I authorize 1816 Pediatrics to use and/or disclose certain protected health information (PHI) about me / my child. I also understand that I may revoke this authorization at any time, in writing, to the address listed below provided the information has not been released.

I authorize:

1816 Pediatrics
2967 Oak Run Pkw., Suite 305
New Braunfels, TX 78132
P (830) 626-1816
F (830) 215-4967

to release to:

_____
New Provider, Specialist, or Person Receiving Copy

_____
Street Address

_____
City, State, ZIP

_____
Phone#

For Patient or Legal Guardian Copy Requests: ( ) Paper ( ) Email ( ) Fax

- I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies, electronic devices, labor, and postage related to the production of my information. I understand that the charge for paper copy is: **$25 for the first 50 pages, then $.50 a page for each page thereafter.**

***Information to be Released/Requested*:** ( ) All pertinent medical records to include X-rays/Labs ( ) Immunization Record

( ) Problem List ( ) Last Well Exam ( ) Growth Chart ( ) ADHD History ( ) Drug Allergy History ( ) Medication List

***Information to be Excluded / Not Released*:** ( ) Mental Health Records ( ) Drug/Alcohol Treatment

( ) HIV Testing ( ) Sexual Assault/Victimization Records ( ) Other: _____

Reason for Record Release*:** ( ) Personal copy (see above – charges apply)*** ( ) Over age 21 ( ) Continuity of Care

( ) Change of Insurance ( ) Referral to Specialist ( ) Moving out of state ( ) Leaving Practice

( ) Unhappy due to wait time ( ) Unhappy due to Customer Service

( ) Unhappy with Provider or Practice (Please state why) _____

***Inspection requests are valid on the date of signature only / Release or Copy requests expire 30 days from signature date**
***Please allow up to 30 days for processing**

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/legal guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).

FORM B 2/03, rev. 4/03, 10/03, 1/04, 4/04, 1/05, 8/05, 9/13, 12/13, 05/14, 10/15, 08/17, 02/19